**Application for Enrollment 2024**

**Please submit completed form with non-refundable $35 processing fee**

Camper Name: Date of Birth: Age: School: Grade:

Parent Names: Home Phone:

Address: E-mail: Cell (parent): Cell (parent) Alternate Email(optional):

Work Phone (parent) Work Phone (parent)

**Non- Parent Emergency Contact: Relationship:** Phone Number of (non-parent) Emergency Contact: **Camper’s Physician:** **Physician’s Phone:**

## Physician’s Address:

List all Known Allergies: Will Camper Need Medication Administered at Camp? YES NO

List All Medications Currently Taking: Does your child currently receive specialized therapies/services? YES NO

If Yes, please list along with the duration of each therapy/service:

Please indicate which weeks you would like your camper to attend. Campers must enroll for 2 weeks (session 1 or Session 2 or Both)

Session 1 Session 2

 WEEK 1 (July 8-July 12) WEEK 3 (July 22- July 26)

 WEEK 2 (July 15- July 19) WEEK 4 (July 29- August 2)

## Please list all current medical diagnoses including physical, psychiatric or behavioral. Please also include any health concerns of which we should be aware. Please add any additional information you think may be helpful in placing your camper.

How did you hear about our camp?

Will you need Before/After Care Yes No

#### YOUTH CAMP HEALTH HISTORY CAMPER

Child’s Name:

Current residence:

EMERGENCY CONTACT INFORMATION:

Emergency Contact

(Parent or Legal Guardian): Phone:

2nd Emergency Contact

(Other than Parent Above): Phone:

Primary Care Physician or

other provider of medical care: Phone:

HEALTH INFORMATION:

Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware?  NO

* YES, Explain:

Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child’s camp experience is positive?  NO

* YES, Explain:

IMMUNIZATION INFORMATION:

#### Must list current residence above.

For campers who currently reside **within** the United States, a United States territory, or the District of Columbia: Does the camper have any immunization exemptions because of a parental or guardian objection or medical contraindication?  NO

* YES, List:

For campers who reside **outside** the United States, a United States territory, or the District of Columbia: Attach record of vaccination or immunity on Department form MDH-896.

Parent or Legal Guardian’s Signature Date

MDH-4768 (12/2017)

## Camper Questionnaire

Camper’s Name: Does your camper have any siblings? If so, please list their names/ages: Does your camper have any pets? If so, list type and name of pet: Please list some things that motivate your camper:

What are some of your camper’s strengths? \_

What are some areas of concern with regard to your camper?

Please list some goals you have for your camper:

What are some of your camper’s favorite things?

Please tell us more about your camper (anything you think will be helpful to know will be appreciated!):

# Bug Spray Release Form

**\*Fill this form out only if you wish for your camper to wear bug spray at camp\***

Dear Parent/Guardian- Please apply bu spray to your camper each day prior to their arrival at camp.

Bug spray will be reapplied as needed throughout the camp day. Please be sure to label your child’s bug spray with his/her name and place in your child’s camp supply bin.

Bug Spray will stay at camp and be sent home on Friday.

Camper:

Bug Spray Brand:

Expiration Date:

 Yes, I give permission for staff members at Summer Sensations Camp to assist my camper with bug spray application.

Parent/Guardian Signature Date

***Before/After Care Registration Form***

11015 Old Columbia Road Suite G-118

Columbia, MD 21046 Please note: Before Care begins daily at 8:00 am and After Care ends 410-997-8081 P promptly at 5pm. Campers picked up after 5pm will be

410-997-8082 F charged $1/minute. Payment is due by or before the Monday of the week

 [www.summersensationscamp.com](http://www.summersensationscamp.com/) for which you are registering for care. Late fees will be applied to all unpaid

 summersensationscamp@yahoo.com balances. Before Care will be billed at a rate of $20/day. After Care will be

billed at a rate of $30/day. If your child is registered for both, you will be billed at a rate of $45/day.

## Camper Name:

Address:

Primary Parent/Guardian:

Home Address:

Phone Number: Alt Number:

Work Name/Address:

Authorized Pick-Ups: Permission is given for my child to be released from the program to the following individual, including the above stated parent/guardian. Driver’s License or valid photo ID is required for authorized pick-up.

Name: Relationship:

Address:

Phone Number: Alt Phone:

Emergency Contact:

Relationship: Phone Number:

Please indicate the days you wish to enroll your camper in care. Please indicate before care (bc), after care (ac) or both.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Monday | Tuesday | Wednesday | Thursday | Friday |
|  bc |  bc |  bc |  bc |  bc |
|  ac |  ac |  ac |  ac |  ac |
|  both |  both |  both |  both |  both |

Sunscreen Release Form

Dear Parent/Guardian- Please apply sunscreen to your camper each day prior to their arrival at camp. Sunscreen will be reapplied as needed throughout the camp day. Please be sure to label your child’s sunscreen with his/her name and place in your child’s camp supply bin.

Sunscreen will stay at camp and be sent home on Friday.

Camper:

Sunscreen Brand:

Expiration Date:

SPF:

 Yes, I give permission for staff members at Summer Sensations Camp to assist my camper with sunscreen application.

 No, I do not give permission for staff at Summer Sensations Camp to assist my camper with sunscreen application. I understand that this means my child must self-administer sunscreen.

Parent/Guardian Signature Date

# Photo Release Form

## This release acknowledges Summer Sensations Camp will take pictures of your child during various activities at camp.

I, , give permission to Summer Sensations Camp, LLC to take pictures of my child,

during camp activities. I understand these pictures will be used primarily for weekly camp journals but may also be used for marketing purposes for Summer Sensations, LLC.

Parent Name Camper

Signature/Date

Please note, without a signed photo release, your camper will not be included in group pictures and your camper’s weekly journal will not include photos of camp activities.

Medical Action Plan

Allergies & Medical Conditions

**Name of your Child:** Date: Parent/Guardian Name: Phone Number: Parent/Guardian Name: Phone Number: Pediatrician’s Name: Phone Number:

**Please select your child’s medical condition:**

* Allergies
* Asthma
* Other (please be specific):

**If you selected Box 1, please go on to complete Form A. If you selected Box 2, please go on to complete Form B. If your child has an alternate medical condition that fits under Box 3, or “other” please see Form C.**

**Form A) Allergies**

1. **List of Allergies.** Please indicate the severity of each allergy:
2. **Does your child have an Epi-pen? Yes or No**
3. **Please give us instructions on how you would like the Epi-pen administered:**
* If checked, give epinephrine ONLY if my child does not respond to Benadryl.
* If checked, give epinephrine immediately for ANY symptoms if my child was *exposed* to the allergen.
* If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
* If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.
1. **What is the Medical Action Plan recommended by your child’s Pediatrician?**

 \_

1. **Please give us any other details that we should be aware of, in order to care for your child’s allergic reaction on-site:**

**Form B) Asthma**

1. **Please select the Asthma Type that your child experiences:**
* Allergy-Induced Asthma
* Exercise-Induced Asthma
* Cough-Variant Asthma
* Night-time Asthma
1. **Please indicate the frequency that your child uses his/her inhaler:**
* Daily
* Emergency
* Both
1. **Explain your child’s Asthma triggers:**
2. **List the controller medications prescribed to your child, and the usual dosage.**
3. **Does your child suffer from Asthma attacks? Yes or No**
4. **What symptoms are usually present when your child is experiencing an Asthma attack?**
5. **What is the Medical Action Plan recommended by your child’s Pediatrician?**
6. **Please give us any other details that we should be aware of regarding your child’s medical condition:**

**Form C) Alternate Medical Condition**

1. **Please inform us of your child’s medical condition:**
2. **List the medication prescribed to your child, and the usual dosage.**
3. **What is the Medical Action Plan recommended by your child’s Pediatrician?**
4. **Please give us any other details that we should be aware of regarding your child’s medical condition:**

\*If there is any additional information you would like to include, please write this on the space provided below.

**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM** Maryland Department of Health (MDH)

### for Youth Camps in Maryland

####  Page 1 of 2

Office of Healthy Homes and Communities

Please complete both pages of this form if the child has an inhaler or other asthma-related medication (410) 767-8417 or 1-877-463-3464 ext. 78417

|  |  |  |  |
| --- | --- | --- | --- |
| 1. CHILD'S NAME (First Middle Last) | 2. DATE OF BIRTH (mm/dd/yyyy) |  | 3. PEAK FLOW PERSONAL BEST: |
|  / /  |  |  |
| 4. ASTHMA SEVERITY (check one):  Mild Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  Exercise Induced |
| 5. ASTHMA TRIGGERS (check all that apply): Colds Exercise Animals Dust Smoke Food Weather Other  |
| **Section I. ASTHMA ACTION PLAN** |
| 6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED |  | 6a. FROM (mm/dd/yyyy) | 6b. TO (mm/dd/yyyy) |
| during the year in which this form is dated in 9b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR. |  / /  |  / /  |
| **GREEN ZONE - DOING WELL** |
| You have **ALL** of these | **Medication Name** | **Dose** |  | **Route** | **Frequency** | **OK to Self-Administer** |  |
| Breathing is good |  |  |  |  | * Yes  No
 |
| No cough or wheeze | *Known side effects:* |
| Can walk, exercise, & play |  |  |  |  | * Yes  No
 |
| Can sleep all night | *Known side effects:* |
| **If known, peak flow greater** |  |  |  |  | * Yes  No
 |
|  | **than (80% personal best)** | *Known side effects:* |
|  | **Exercise Zone** |
|  |  | **Rescue Medication** | **Dose** |  | **Route** | **Frequency** | **OK to Self-Administer** | **OK to Self-Carry** |
| * Prior to all exercise/sports
 |  |  |  |  | * Yes  No
 | * Yes  No
 |
| * When the child feels they need it
 | *Known side effects:* |
| **YELLOW ZONE - GETTING WORSE** |
| You have **ANY** of these | **Emergency Medication** | **Dose** |  | **Route** | **Frequency** | **OK to Self-Administer** | **OK to Self-Carry** |
| Some problems breathing Wheezing, noisy breathing Tight chestCough or cold symptoms Shortness of breathOther: **If known, peak flow between** **and (50% to 79% personal best)** |  |  |  |  | * Yes  No
 | * Yes  No
 |
| *Known side effects:* |
|  |  |  |  | * Yes  No
 | * Yes  No
 |
| *Known side effects:* |
|  |  |  |  | * Yes  No
 | * Yes  No
 |
| *Known side effects:* |
| **RED ZONE - MEDICAL ALERT/DANGER** |
| You have **ANY** of these | **Emergency Medication** | **Dose** |  | **Route** | **Frequency** | **OK to Self-Administer** | **OK to Self-Carry** |
| Breathing hard and fast Lips or fingernails are blue Trouble walking or talkingMedicine is not helping (15-20 mins?) Other: **If known, peak flow below (0% to 49% personal best)** |  |  |  |  | * Yes  No
 | * Yes  No
 |
| *Known side effects:* |
|  |  |  |  | * Yes  No
 | * Yes  No
 |
| *Known side effects:* |
|  |  |  |  | * Yes  No
 | * Yes  No
 |
| *Known side effects:* |

MDH-4758-C (01/2019) **Please turn over - this form has 2 pages with four total sections Keep for 3 Years**

**ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM** Maryland Department of Health (MDH)

### for Youth Camps in Maryland

####  Page 2 of 2

Office of Healthy Homes and Communities

Please complete this form if the child has an inhaler or other asthma-related medication (410) 767-8417 or 1-877-463-3464 ext. 78417

|  |  |  |  |
| --- | --- | --- | --- |
| CHILD'S NAME (First Middle Last) | DATE OF BIRTH (mm/dd/yyyy) |  |  |
|  | / / |  |
| **Section II. PRESCRIBER'S AUTHORIZATION** |
| 8. PRESCRIBER'S NAME/TITLE | This space may be used for the Prescriber's Address Stamp |
| TELEPHONE | FAX |
| ADDRESS |
| CITY | STATE | ZIP CODE |
| 9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) |  |  |  |  |  |  | 9b. DATE (mm/dd/yyyy) |
| (original signature or signature stamp only) |  |  |  |  |  |  |  |  |
| **Section III. PARENT/GUARDIAN AUTHORIZATION** |
| I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA |
| 10a. PARENT/GUARDIAN SIGNATURE | 10b. DATE (mm/dd/yyyy) | 10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION |
| 10d. HOME PHONE # | 10e. CELL PHONE # | 10f. WORK PHONE # |
| **Section IV. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)** |
| THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry. |
| I authorize self-administration of all of the medications listed in *Section I: Asthma Action Plan* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I: Asthma Action Plan* , the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry." |
| 11a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY | 11b. DATE (mm/dd/yyyy) |
| 12a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY | 12b. DATE (mm/dd/yyyy) |
| **Section V. CAMP MEDICAL STAFF USE ONLY** |
| Camp Medical Staff Notes: |
| Reviewed by: | DATE (mm/dd/yyyy) |

MDH-4758-C (01/2019) **Please turn over - this form has 2 pages with four total sections Keep for 3 Years**

**MEDICATION ADMINISTRATION AUTHORIZATION FORM** tor Youth camps in Maryland Maryland Department of Health (MOH)

This form must be completed fu!!y in order for youth camp operators and staff members to adminter the required medication or for the camper to self-adminster medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.

Office of Healthy Homes and Communities

(410) 767-8417 or 1-877-4MD-DHMH ext. 8417

Draft Revision Date: 4/4/2018

* Nonprescription medication must be in the original container with the instructions for use. Non prescription medication includes vitamins, homeophathic, and herbal medicines.

-An adult must bring the medication to the camp and give the medication to an adult staff member

**Section** I. **PRESCRIBER'S AUTHORIZATION**

* 1. CHILD'S NAME (First Middle Last) 12. DATE OF BIRTH (mm/dd/yyyy)

*j J*

1. MEDICATION SHALL BE ADMINISTERED 3a. FROM (mm/dd/yyyy) 3b. TO (mm/dd/yyyy)

during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOTTO EXCEED 1 YEAR.

 *j j*

 *j j*

Medication Name Condition Being Treated/PRN Parameters Dose Route Frequency **OK to Self-Administer OK to Self-Carry (Emerg Meds Only)**

* 1. I joves 0 No loves 0 No o Not emergency med

*Emergency Medication:* o *Yes* o *No Known side effects:* .

* 1. I loves 0 No loves 0 No o Not emergency med

*Emergency Medication:* o *Yes* o *No Known side effects:*

* 1. I loves 0 No loves 0 No o Not emergency med

*Emergency Medication:* o *Yes* o *No Known side effects:*

1. PRESCRIBER'S NAME/TITLE This space may be used for the Prescriber's Address Stamp TELEPHONE **FAX**

ADDRESS

CITY STATE jZIP CODE

Sa. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) ISb. DATE (mm/dd/yyyy)

orii;;inal sii;;nature or sii;;nature stamo on!v)

**Section** II. **PARENT/GUARDIAN AUTHORIZATION**

I request the authorized youth camp operator, staff member or volunteer to administer the medication orto supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded.I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

6a. PARENT/GUARDIAN SIGNATURE 16b. DATE (mm/dd/yyyy) 16c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

6d. HOME PHONE# I6e. CELL PHONE# I6f. WORK PHONE#

**Section** Ill. **AUTHORIZATION FOR SELF-ADMINISTRATION/ SELF-CARRY (OPTIONAL)**

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION-PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self carry.

1 authorize self-administration of a!! of the medications listed in *Section I* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. !f indicated in *Section f,* the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

8b. DATE

|  |  |  |
| --- | --- | --- |
| 7a. PRESCRIBER'S SIGNATUREFOR SELF·ADMINISTRAllON/SEl.F-CARRY | 17b. DATE | 1sa. PARENT/GUARDIAN'S SIGNATUREFOR SELF-ADMINISTRAT10N/SELF-cARRY |
| MDH-4758-A (01/2019) |  |  |